STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CUMBERLAND HEALTH CARE AND REHABILITATION INC	4343 ASHLAND CITY HWY NASHVILLE, TN 37218

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F 000	INITIAL COMMENTS A complaint survey was conducted at Cumberland Health Care and Rehabilitation on 9/11-13/17. No deficiencies were cited related to complaint investigation #41835. Deficiencies were cited for complaint investigation #41042, #41475, #42163, #42301, and #42364 42 CFR PART 483, Requirements for Long Term Care Facilities.	F 000		
F 224 SS=E	483.12(b)(1)-(3) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms. 483.12(b) The facility must develop and implement written policies and procedures that: (b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (b)(2) Establish policies and procedures to investigate any such allegations, and (b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on facility policy review, medical record reivew, facility investigation review, observation, and interview, the facility failed to prevent misappropriation of resident narcotic medication	F 224		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 224	Continued From page 1 for 7 residents (#1, #2, #3, #4, #5, #8, #11) of 16 residents reviewed for abuse. The findings included: Review of facility policy, Abuse, effective 7/2014, revealed "...The facility practices the concept of "zero tolerance" for patient abuse. Nurse management must strive to ensure the patients are free from verbal, sexual, physical and mental abuse, corporal punishment, involuntary seclusion, and misappropriation of property. ANY report of actual or suspected abuse MUST be acted upon immediately...Conduct a thorough investigation that is well documented..." Review of facility policy, Controlled Medications, revealed "...All nurses must be inserviced on the procedure for accountability for controlled drugs on hire and annually thereafter..." Review of facility policy, Controlled Drug Accountability Procedure, effective 7/2014, revealed :...Each dose administered is to be signed out by the nurse on the controlled drug record and on the patient's eMAR [electronic Medication Administration Record]. Follow-up documentation for effectiveness should be accomplished on the eMAR also...The count of each controlled substance must be audited at every shift change by the nurse coming on duty and the nurse going off duty. Visual checks of the entire medication card for missing medications and the record sheet must be done by both nurses...Both nurses must sign the Narcotic Control Record indicating the count has been completed; the date, time, number of medication cards, and the number of controlled drug record sheets must be documented...If the count is	F 224		

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F 224	Continued From page 2 incorrect the Director of Nursing (DON) must be notified immediately. No exchange of med cart keys should be done and the off-going nurse should not leave the facility..." Review of facility policy, Destruction of Medications, effective 7/2/14, revealed "...Each facility medication room must have a container labeled for the collection of all patients' medication to be considered for credit or destruction...Controlled medications set to destroy must be destroyed by the Director of Nursing (DON) or designee and the consultant pharmacist..." Medical record review revealed Resident #1 was admitted to the facility on 8/1/17 with diagnoses including Atherosclerotic Cardiovascular Disease, Post Traumatic Stress Disorder, Gastroesophageal Reflux Disease, Deep Vein Thrombosis, Diabetes Mellitus, Hypertension, and Chronic Pain. Medical record review of the Admission Minimum Data Set (MDS) dated 8/6/17 revealed Resident #1 scored 15 on the Brief Interview for Mental Status (BIMS) indicating he was alert, oriented, and able to make his needs known. Continued review revealed Resident #1 required extensive assistance with transfers and bathing; limited assistance with dressing and grooming; and supervision with eating. Medical record review of Physician's Orders dated 8/6/17 revealed Resident #1 was ordered Oxycodone 7.5/325 milligrams (mg) every 6 hours as needed for pain. Review of the Controlled Drug Record revealed	F 224		

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F 224	Continued From page 3 on 8/15/17, Oxycodone 7.5/325 mg was signed out at 9:00 PM, 10:00 PM, 2:00 AM. Continued review revealed Oxycodone was also signed out on 8/16/17 at 6:00 AM, all by the same Agency Nurse #1. Medical record review of the Medication Administration Record (MAR) revealed Oxycodone 7.5/325 mg was documented as administered at 3:40 PM on 8/15/17 and at 1:33 PM on 8/16/17. None of the other times from the evening and night shifts were documented on the MAR. Review of the facility investigation revealed Resident #1 was interviewed on 8/16/17 and stated he received pain medication about 8:30 PM on 8/15/17 but did not receive any pain medication during the night on the 11:00 PM - 7:00 AM shift and he slept through the night. Medical record review revealed Resident #2 was admitted to the facility on 12/24/13 with diagnoses including Diabetes Mellitus, Hypertension, Dementia, Obstructive Sleep Apnea, Bipolar Disorder, Seizures, and Colostomy. Medical record review of the Quarterly MDS dated 9/1/17 revealed Resident #2 scored 15 on the BIMS indicating she was alert, oriented, and able to make her needs known. Medical record review of Physician's Orders dated 2/17/17 revealed Resident #2 was ordered Oxycodone 7.5/325 mg every 4 hours as needed for pain. Review of the Controlled Drug Record revealed Oxycodone 7.5/325 mg was signed out at 12:00	F 224		

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F 224	Continued From page 4 AM, 2:00 AM, 6:00 AM, 6:45 AM, and 6:55 AM, all by Agency Nurse #1. Continued review of the record revealed only 1 tablet was signed out at 12:00 AM but the count was documented as 29 before the tablet was removed and 27 after the tablet was removed. Further review revealed only 1 tablet was signed out at 2:00 AM but the count was documented as 27 before the tablet was removed and 25 after the tablet was removed. Continued review revealed 1 tablet was signed out at 6:00 AM but the count was documented as 25 before the tablet was removed and 23 after the tablet was removed. Further review revealed at 6:45 AM and 6:55 AM Agency Nurse #1 documented removing 2 tablets each time. Medical review of the MAR revealed Oxycodone 7.5/325 mg was documented as administered on 8/15/17 at 10:53 PM but nothing was documented for 8/16/17. Review of the facility investigation revealed Resident #2 was interviewed on 8/16/17 and she stated she received pain medication on the 3:00 PM - 11:00 PM shift but did not have any pain medication during the night and was not having any increase in her pain. Observation of Resident #2 on 9/11/17 revealed she was lying in bed watching TV. She stated the pain medication was effective in controlling her pain and she receives pain medication when she asks for it. Medical record review revealed Resident #3 was admitted to the facility on 7/8/16 with diagnoses including Hypertension, Chronic Kidney Disease, Diabetes Mellitus, Dementia, and Decreased Mobility.	F 224		

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F 224	Continued From page 5 Medical record review of the Annual MDS dated 6/30/17 revealed Resident #3 scored 13 on the BIMS indicating she had slight cognitive impairment. Medical review of Physician's Orders dated 7/21/17 revealed Resident #3 was ordered Oxycodone 5/325 mg every 12 hours as a scheduled medication. Review of the Controlled Drug Record dated 8/5/17 revealed Oxycodone 5/325 mg was signed out at 6:00 PM and 11:00 PM while on 8/6/17 it was signed out at 6:00 AM, 5:00 PM, and 11:00 PM. Continued review revealed on 8/7/17 Oxycodone was signed out at 5:30 AM, 9:00 PM, and 11:00 PM while on 8/9/17 it was signed out at 9:30 PM, 10:30 PM, and one was wasted at 11:30 PM. Further review revealed on 8/10/17 Oxycodone was signed out at 6:00 AM and on 8/13/17 was signed out at 12:00 AM and 6:00 AM. Continued review revealed on 8/14/17 Oxycodone was signed out at 12:00 AM, again for 12:00 AM, 6:00 AM, 6:30 AM, and 6:50 AM. Further review revealed on 8/15/17 Oxycodone was signed out at 4:00 PM and 10:00 PM while on 8/16/16 it was signed out at 12:00 AM, 6:00 AM, and 6:45 AM. All of these removals were signed out by Agency Nurse #1. Medical record review of the MAR revealed the only documentation of administration of Oxycodone was 8/7/17 at 5:30 AM. There was no documentation for the rest of the tablets of Oxycodone which were removed. Observation of Resident #3 on 9/11/17 at 1:50 PM revealed her lying in bed asleep. Observation	F 224		

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F 224	Continued From page 6 on 9/12/17 at 8:05 AM revealed the resident was in bed watching TV and stated she had no pain currently. Medical record review revealed Resident #4 was admitted to the facility on 7/20/17 with diagnoses including Hypertension, Gastroesophageal Reflux Disease, Acute Kidney Failure, and Paraplegia. Medical record review of the Admission MDS dated 7/27/17 revealed Resident #4 scored 15 on the BIMS, indicating he was alert, oriented, and able to make his needs known. Medical record review of Physician's Orders dated 7/20/17 revealed an order for Oxycodone 5 mg IR (Immediate Release) 1 tablet every 6 hours as needed for pain. Review of the Controlled Drug Record revealed on 8/5/17 Oxycodone was signed out at 6:15 PM and 11:45 P0 AM; on 8/12/17 it was signed out at 2:00 AM; on 8/13/17 it was signed out at 3:15 AM; on 8/14/17 it was signed out at 12:00 AM and 6:00 AM; on 8/15/17 it was signed out at 7:00 PM' and on 8/16/17 it was signed out at 1:00 AM. All these removals were signed out by Agency Nurse #1. Medical record review of the MAR revealed no documentation on the MAR of any of these medications being administered. Observation of Resident #4 on 9/11/17 at 1:40 PM revealed Resident #4 sitting up in bed with Podus boots on both lower extremities. He stated his pain was controlled with medication. Observation of the resident on 9/12/17 at 8:10 AM revealed Resident #4 revealed he was still	F 224		

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F 224	Continued From page 7 asleep with the door closed. Medical record review revealed Resident #5 was admitted to the facility on 4/28/17 with diagnoses including Acute Respiratory Failure, Tension Pneumothorax, Cerebrovascular Accident with Right Hemiplegia, Hypertension, and Chronic Pain. Medical record review of the Quarterly MDS dated 8/1/17 revealed Resident #5 scored 3 on the BIMS indicating she was severely impaired cognitively. Medical record review of Physician's Orders dated 4/28/17 revealed Resident #5 was ordered Oxycodone 5/325 mg three times daily. Review of Controlled Drug Record dated 8/3/17 revealed Oxycodone was signed out at 5:00 PM, 10:00 PM, 11:00 PM, again at 11:00 PM, and 11:30 PM. Continued review revealed on 8/4/17 Oxycodone was signed out at 5:00 PM, 5:30 PM, 10:30 PM, and 11:00 PM. Further review revealed on 8/6/17 Oxycodone was signed out at 5:00 AM, 5:00 PM, and 11:00 PM. Continued review revealed on 8/12/17 Oxycodone was signed out at 12:00 AM, 4:00 AM, and 6:00 AM while on 8/13/17 it was signed out at 12:00 AM and 6:00 AM. Further review revealed on 8/14/17 Oxycodone was signed out at 12:00 AM and 6:00 AM while on 8/15/17 it was signed out at 10:00 PM, 10:30 PM, 12:00 AM, and 6:00 AM. These removals were all signed out by Agency Nurse #1. Medical record review of the MAR revealed none of these removals were documented as having been administered.	F 224		

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F 224	Continued From page 8 Observation of Resident #5 on 9/12/17 at 8:15 AM revealed the resident lying uncovered in bed, yelling out unintelligibly. When the CNA entered the room she spoke with the resident but was unable to understand what was wanted. Review of the facility investigation revealed the discrepancies were discovered when Resident #2 asked RN #1 for pain medication on 8/16/17. When RN #1 looked at the Controlled Drug Record to determine when the last dose of Oxycodone was administered she saw the count on the 3:00 PM - 11:00 PM was 29 tablets and the count at the 11:00 PM - 7:00 AM shift was 19 tablets. At the same time RN #1 noted the frequency with which Oxycodone was signed out. At this point she shared her concerns with the Administrator. Both the Administrator and DON began an investigation, looking at all the Controlled Drug Records for all residents. They interviewed the residents who had Oxycodone signed out during the night shift as to when they last received pain medication and if they received any pain medication during the night of 8/15/17 - 8/16/17. All the residents stated they had pain medication on evenings but had not required any during the night. The Administrator and DON reviewed MARs for those residents and found concerns. At this point they had narrowed the concern to Agency Nurse #1 and they began to watch the video footage of the night shift. They determined the discrepancies with all 5 residents included the times on the Controlled Drug Record were not on the MAR; the times on the controlled Drug Record do not match the video footage; and times on the controlled Drug Record do not match the Physician's Orders. Drug screens were ordered on all nurses with access to the	F 224		

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F 224	Continued From page 9 Oxycodone of Resident #2 and all were negative. At this point the agency was notified Agency Nurse #1 was to be removed from the facility rotation. The Administrator spoke with the Branch Manager of the staffing agency regarding her concerns with Agency Nurse #1. The Branch Manager reviewed the videos and terminated Agency Nurse #1 from the agency. Review of the video footage from 8/15/17 and 8/16/17 revealed Agency Nurse #1 not entering the room of Resident #1 except for morning medication pass. On 8/15/17 she is seen at 8:02 PM flipping through the Controlled Drug Records then she places an empty cup on the cart. She opens the narcotic box; takes out a pill and places it in the cup. She goes to another card; flips out a tablet and adds it to the cup; flips through the book a third time; removes a narcotic from a card; and adds it to the cup. She fills a cup with water and walks around for 30 minutes. She enters the room of Resident #4 at 8:25 PM and exits at 8:34 PM with no cups. Resident #4 is only on 1 narcotic. On 8/16/17 at 3:48 AM she is seen flipping through narcotic cards in the narcotic drawer; reaching to the left and placing something on the med cart; filling a cup with water; walking into the medication room; and not returning with anything. At 6:45 AM she is seen removing a tablet from the narcotic card; filling a cup with water; walking down the hall to a room on the right which was not the room of any of the residents; and coming out of the room with nothing. On 8/16/17 Agency Nurse #1 signed out Oxycodone for Resident #3 at 5:05 AM and 5:55 AM but the video showed her at the medication card checking narcotic cards in the box and comparing them to the Controlled Drug Records.	F 224		

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F 224	Continued From page 10 Interview with Registered Nurse (RN #1) on 9/12/17 at 1:35 PM in the conference room revealed she was the nurse on 7:00 AM - 3:00 PM. Continued interview revealed Resident #2 was in her care and asked for something for pain. Further interview revealed RN #1 checked the Controlled Drug Record to see when the last dose was given. Continued interview revealed she notes the date and times of Oxycodone withdrawal as well as the fact the count at 11:00 PM was 29 Oxycodone remaining and at 7:00 AM there were only 19 remaining. Further interview revealed she noted 1 tablet was removed at times and 2 tablets were removed at others. Continued interview revealed she also saw Oxycodone signed out at 6:15 AM and again at 6:45 AM so she pulled the sign out sheet and took it to the Administrator. Interview with the Administrator on 9/12/17 at 2:20 PM in the Administrator's Office, revealed when RN #1 brought the sign out sheet to her with her concerns, she and the DON began pulling sign out sheets from other residents. All nurses with access to the Oxycodone of Resident #2 were drug tested and all were negative. In reviewing the sign out sheets the Administrator and DON determined there were many irregularities in narcotics signed out and they pointed to Agency Nurse #1. They began watching the video footage of 8/15/17 and 8/16/17 to compare sign out times with times Agency Nurse #1 entered resident rooms. When they found many discrepancies the Administrator contacted the staffing agency to request the nurse not be sent back to the facility. When she spoke to the Branch Manager and the Manager viewed the video footage, the nurse was terminated and reported to the Board of Nursing.	F 224		

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F 224	Continued From page 11 In summary, Residents #1, #2, #3, #4,and #5 had Oxycodone signed out on the Controlled Drug Record at various times but there was no corresponding documentation on the MAR of medication administration. The Oxycodone was signed out consistently by Agency Nurse #1. Review of video footage showed her flipping through narcotic cards and the Controlled Drug Record and removing narcotics. The videos also failed to show Agency Nurse #1 entering the rooms of these residents at the times the medications were signed out. Residents #1, #2, #3, #4 who were alert and oriented, stated they received no Oxycodone during the 11:00 PM - 7:00 AM shift but Agency Nurse #1 had signed out Oxycodone as having been administered during that time. Medical record review revealed Resident #8 was admitted to the facility on 12/7/16 with diagnoses including Trunk Cellulitis, Congestive Heart Failure, Chronic Pain, Hypertension, Obstructive Sleep Apnea, Morbid Obesity, Peripheral Vascular Disease, and Respiratory Failure. Resident #8 was discharged on 3/4/17. Medical record review of Physician's Admission Orders dated 12/7/16 revealed Resident #8 was ordered Oxycodone 5/325 milligrams (mg) for pain. Review of the facility investigation revealed on 3/13/17 at 2:00 AM Licensed Practical Nurses (LPN) #5 and #6 signed the Discontinued Narcotic Control Record that 27 tablets of Oxycodone 5/325 mg were placed in the lock box. Continued review revealed on 3/21/17 the DON and Pharmacist signed the Discontinued	F 224		

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F 224	Continued From page 12 Narcotic Control Record that the Oxycodone was not destroyed. Further review revealed the card with 27 tablets of Oxycodone was missing along with the sign-out sheet. Continued review revealed the medication room as well as the medication cart were searched and the card of Oxycodone was not found. Further review revealed the two nurses who placed the card in the locked box and another nurse who had access to the box were all drug tested and were negative. Continued investigation revealed the previous Administrator has obtained a key to the lock box but was not available for drug testing. Review of a written statement from LPN #5 dated 3/21/17 revealed "...on 3/13/17 [LPN #6] asked him to drop a narcotic card for a discharged patient, [Resident #8]. The card contained Oxycodone 5/325 mg #27 remaining in pack. This nurse opened top of discontinued narcotic box, the med card was inserted by the nurse [LPN #6] who then had to forcefully shut the door twice to get med to drop. Both nurses then verified med had dropped. This nurse locked door back and both nurses left the med room..." Review of a written statement from LPN #6 revealed "...I went to discard [Resident #8] Oxycodone due to the resident being discharged. I and [LPN #5] went to the med room. I logged med into the book. [LPN #5] had key to drop box and unlocked box. [LPN #5] and myself both verified the amount of meds on card. Card was wrapped with the narcotic sheet and rubber band applied. Meds with sheet put into box. Med dropped and door slammed x 2. Med dropped down into box and [LPN #5] locked box. We both walked out of med room together..."	F 224		

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	445262	A. BUILDING _____ B. WING _____	C 09/13/2017

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F 224	Continued From page 13 Review of a written statement from Registered Nurse (RN) #3 who was the only other person placing medications into the locked box revealed "...On 3/13/17 I witnessed and documented a narcotic destruction with another nurse. The narcotic was placed in the narcotic box located in the medication room of the facility. All cards of narcotics removed from the cart dropped into the box. The narcotic box was locked back afterwards..." Interview with LPN #6 on 9/12/17 at 6:45 AM at the nurses' station revealed she and LPN #5 disposed of the Oxycodone from Resident #8. She completed the log while LPN #5 opened the lock box. They had a card of Oxycodone with 27 pills remaining in it. They wrapped the sign-out sheet around the card of pills and secured it with a rubber band. They dropped the card in the box and heard it fall. LPN #5 locked the box and they both left the medication room. Interview with the Administrator on 9/13/17 at 2:20 PM in the Administrator's office revealed the three nurses were drug tested and were negative. Continued interview revealed the previous Administrator had Maintenance make him a key for the lock box but he had been terminated so could not be drug tested. Further interview confirmed the card and 27 pills were not located even after a completed search of the lock box, medication room, and medication carts. Medical record review revealed Resident #11 was admitted to the facility on 11/10/15 with diagnoses including Chronic Obstructive Pulmonary Disease, Diabetes Mellitus, Morbid Obesity, Schizophrenia, Obstructive Sleep Apnea, Chronic Pain, Hypertension, Atrial Fibrillation, Congestive	F 224		

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F 224	Continued From page 14 Heart Failure, and Gastroesophageal Reflux Disease. Medical record review of the Quarterly MDS dated 8/7/17 revealed Resident #11 scored 12 on the BIMS, indicating she was slightly cognitively impaired. Medical record review of Physician's Orders dated 7/12/17 revealed Resident #11 was ordered Norco 10/325 mg every 8 hours as needed. Review of the Controlled Drug Record revealed 60 tablets of Norco 10/325 mg were delivered to the facility on 6/2/17. Continued review of the record revealed under Quantity Received and Quantity Dispensed, the 60 had been overwritten with 30. Further review revealed the only withdrawal occurred on 9/5/17 by LPN #2. Review of the facility investigation revealed the Pharmacy was called and verified 60 tablets were delivered to the facility. The delivery manifest was given to the facility which showed 60 tablets delivered. The second card with 30 tablets of Norco and the Controlled Drug Record were missing and have not been located. Observation of Resident #11 on 9/13/17 at 9:35 AM revealed her in bed asleep with somewhat labored respirations and a dressing over her right eye from recent surgery. Interview with the Administrator on 9/13/17 at 2:20 PM confirmed medications had been misappropriated from residents.	F 224		
F 225 SS=D	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS	F 225		

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F 225	Continued From page 15 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if	F 225		

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F 225	Continued From page 16 the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on facility policy review and interview, the facility failed to properly complete an investigation for 1 resident (#9) of 17 residents reviewed. The findings included: Review of facility policy, Investigation" dated June 2014 revealed "...Request written statements from persons who may have knowledge of the incident..." Medical record review revealed Resident #9 admitted to facility on 5/13/16 with diagnoses including Bipolar Disorder, Anxiety Disorder,	F 225		

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F 225	Continued From page 17 Brown-Sequard Syndrome, Drug or Chemical Induced Diabetes Mellitus, Left Foot Drop, Hyperlipidemia and Necrotizing Vasculopathy. Medical record review of the Quarterly Minimum Data Set dated 8/17/17 revealed Resident #9 had a Brief Interview of Mental Status of 15, indicating she was cognitively intact. Review of a facility completed abuse investigation revealed a list of staff interviewed on 9/6/17 by the Assistant Director of Nursing/Registered Nurse (RN) #2 and the Risk Manager/Licensed Practical Nurse (LPN) #4. There was a hand written list with staff names and short statements beside each name (8 total) all in the same handwriting. There were 8 individually hand written statements dated 9/6/17, all in the same handwriting but a different handwriting from the list. Interview with RN #2 on 9/12/17 at 3:15 PM in her office revealed she wrote the list of the staff names and what that staff told her located in the facility completed investigation. RN #2 confirmed she failed to obtain written statements from the staff for the investigation of abuse to Resident #9. Interview with LPN #4 on 9/12/17 at 3:43 PM in her office revealed she wrote the 8 hand written individual statements located the facility completed investigation. LPN #4 confirmed she failed to obtain written statements for the investigation of abuse to Resident #9. Interview with the Administrator on 9/12/17 at 3:50 PM in her office confirmed the facility failed to obtain written statements from the staff that were interviewed and Resident #9 in the	F 225		

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F 225	Continued From page 18 investigation of abuse to Resident #9.	F 225		
F 250 SS=D	483.40(d) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE (d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on facility policy review, medical record review and interview the facility failed to provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being for 1 resident (#10) of 17 residents reviewed. The findings included: Review of facility policy, Social Services, dated March 2016 revealed "...Social workers are to provide support to the patient and their families and other individuals involved with the patient's care. Social workers are to be the patient's advocate to ensure they receive appropriate care and treatment..." Medical record review revealed Resident #10 was admitted to the facility on 4/9/12 with diagnoses including Bilateral Blindness, Type II Diabetes Mellitus, Vascular Dementia, Peripheral Vascular Disease, Gastro-Esophageal Reflux Disease, Bipolar Disorder, Arthropahty, Hypertension, Hypokalemia, Anemia, Rheumatoid Arthritis, Stage 3 Pressure Ulcer of Left Buttocks & Muscle Wasting & Atrophy. Medical record review of the Quarterly Minimum	F 250		

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F 250	Continued From page 19 Data Set dated 6/24/17 revealed Resident #10 had a Brief Interview for Mental Status of 4 indicating she was severely cognitively impaired. Further review revealed the resident had no impairment of the lower extremities and was not steady, only able to stabilize with staff assistance with moving from seated to standing position, moving on/off toilet and surface-to-surface transfer. Medical record review of a Clinical Note dated 5/18/17 revealed edema in right ankle. Resident #10 expressed facial grimaces when the nurse touched the ankle and declined to get out of bed. Medical record review of a Physician Assessment dated 5/19/17 revealed "...Pt's [patient's] rt [right] ankle swollen, erythemoatous, possible deformity noted. Very painful [with] palpitation. Pt doesn't recall any injury to ankle. Was called last night regarding pain to pts hip/ankle, ordered uric acid level for today which is [negative] will get xray..." Medical record review of a Radiology Report dated 5/19/17 revealed "...There are comminuted angulated and mildly displaced acute fractures of the distal tibia and distal fibula, well above the joint space. The bones are osteopenic. There appears to be narrowing of the ankle joint. No there acute fractures seen. No other incidental findings...Acute fracture of the distal tibia and fibula..." Medical record review of a Clinical Note dated 5/19/17 revealed the Nurse Practitioner (NP) ordered an xray of the resident's right ankle. The findings showed comminuted and mildly displaced acute fracture of the tibia and fibula above the joint. The NP ordered the resident to	F 250		

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F 250	Continued From page 20 be sent to Emergency Department (ED). Medical record review of an ED report dated 5/19/17 revealed Resident #10 had a "...tib-fib [tibia-fibula] fracture..." which was splinted. The resident was to follow-up with the Orthopedic Physician within 5 to 7 days. Review of a medical record report dated 7/21/17 revealed Resident #10 had a follow-up appointment with an orthopedic specialist. Further review revealed "...She was seen on May 19, 2017, when x-rays at nursing facility showed a right distal tibia fracture. She was placed in a splint, but unfortunately never followed up until this week. She is here with her daughter. I questioned her daughter why they never brought her back even with the followup information that I clearly showed her and that the daughter had with her today and the daughter says she just thought the nursing home would do it...when we touched her right leg, she started screaming...There is a procurvatum deformity at the right distal tibia and equinus flexion contracture of the ankle...Right distal third extraarticular tib-fib fracture sustained 2 months ago, was seen in the ER and told to followup and has not until now...patient is not an operative candidate. Will have to balance the orthopedic treatment for trying to get the bone to heal with risk of skin breakdown and this really is more palliative than anything. She may have a nonunion of the tibia that we treat with bracing long term...we will put her in a short leg cast for some stability at the fracture site. Hopefully this will stimulate some healing...will see her back in a month. We can cut cast off, get another set of x-rays and check on her symptoms. She may be a candidate for a molded removable splint, that may be a good long term option for her..."	F 250		

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F 250	Continued From page 21 Review of Resident #10's medical records from March 2017 until Sept 2017 revealed the resident was never seen by social services. Review of a medical record dated 3/6/17 by social services revealed "...[Resident #10] received mental health services on this date. A clinical noted has been provided and will be scanned into the system for staff review. This social worker will assist [Resident #10] with any social services needs as they arise..." Interview with the Social Worker (SW) #1 on 9/12/17 at 4:30 PM in his office revealed he was responsible for making follow-up appointments. SW #1 stated he was not aware Resident #10 had a fracture. SW #1 confirmed he did not make Resident #10 a follow-up as ordered by the ED physician. SW #1 stated he had not seen Resident #10 from timeframe May 2017-July 2017. Interview with the Administrator on 9/12/17 at 4:42 PM in her office confirmed the facility failed to ensure Resident #10 received a follow-up orthopedic appointment as ordered. Interview with Administrator on 9/13/17 at 12:45 PM revealed she expected social services to have contact with residents at least quarterly if not more. The Administrator confirmed Resident #10 had not been assessed by Social Services from March 2017-September 2017. The Administrator confirmed the facility failed to provide medically related Social Services to attain or maintain the highest practicable physical, mental and psychosocial well-being for Resident #10.	F 250		

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F 309	Continued From page 22	F 309		
F 309 SS=E	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by:	F 309		

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F 309	Continued From page 23 Based on facility policy review, medical record review, facility investigation review, observation, and interview, the facility failed to provide care by failing to follow Physician's Orders for 6 residents (#12, #10, #3, #14, #17) and failed to follow the facility policy for 1 resident (#12) of 17 residents reviewed. The findings included: Review of facility policy, Controlled Drug Accountability Procedure, effective 7/2014, revealed "...Each dose administered is to be signed out by the nurse on the controlled drug record and on the patient's eMAR [Medication Administration Record]. Follow-up documentation for effectiveness should be accomplished on the eMAR also...The count of each controlled substance must be audited at every shift change by the nurse coming on duty and the nurse going off duty. Visual checks of the entire medication card for missing medications and the record sheet must be done by both nurses...Both nurses must sign the Narcotic Control Record indicating the count has been completed; the date, time, number of medication cards, and the number of controlled drug record sheets must be documented...If the count is incorrect the Director of Nursing (DON) must be notified immediately. No exchange of med cart keys should be done and the off-going nurse should not leave the facility..." Medical record review revealed Resident #12 was admitted to the facility on 6/6/14 with diagnoses including Chronic Kidney Disease, Hypertension, Peripheral Vascular Disease, Dementia, and Depression.	F 309		

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F 309	Continued From page 24 Medical record review of the Quarterly Minimum Data Set (MDS) dated 8/17/17 revealed Resident #12 scored 1 on the Brief Interview for Mental Status (BIMS) indicating she was severely impaired cognitively. Medical record review of Physician's Orders dated 5/31/17 revealed Resident #12 was ordered Hydrocodone/APAP 5/325 milligrams (mg) 1/2 tablet every 6 hours as needed for pain. Review of the Controlled Drug Record revealed Hydrocodone was signed out on 8/31/17 and below it were 2 tablets signed out on 8/27/17 or 8/28/17 by Licensed Practical Nurse (LPN #1). Continued review revealed 1/2 tablet was signed out on 6/26/17, 7/14/17, 7/17/17, 7/25/17, and 7/31/17 and 1/2 wasted was documented but there was no signature by the second nurse. Further review revealed 1 tablet signed out on 8/7/17, 8/23/17, 8/25/17, 8/26/17, 8/31/17 but the other had not been changed from 1/2 tablet. Observation of Resident #12 on 9/13/17 at 11:50 AM revealed her seated in her wheelchair in front of the overbed table with a finished lunch tray on it. Her arms were crossed; she was leaning to the left; and was asleep. Medical record review revealed Resident #3 was admitted to the facility on 7/8/16 with diagnoses including Hypertension, Chronic Kidney Disease, Diabetes Mellitus, Dementia, and Decreased Mobility. Medical record review of the Annual MDS dated 6/30/17 revealed Resident #3 scored 13 on the BIMS indicating she had slight cognitive impairment.	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 309	Continued From page 25 Medical record review of Physician's Orders dated 7/22/07 revealed Resident #3 was ordered Oxycodone 5/325 mg every 6 hours as needed. Review of the Controlled Drug Record revealed Resident #3 had Oxycodone signed out on 9/6/17 at 4:00 PM and again at 8:00 PM, not 6 hours apart by LPN #2. These doses were not documented on the Medication Administration Record (MAR) as being administered. Review of the facility investigation revealed the Administrator interviewed Resident #3 and she stated she had not had any pain medication in over a week. Medical record review revealed Resident #15 was admitted to the facility on 4/10/13 with diagnoses including Coronary Artery Bypass Graft, Hypertension, Seizures, Diabetes Mellitus, Peripheral Vascular disease, and Dementia. Medical record review of the Quarterly MDS dated 7/5/17 revealed Resident #15 scored 7 on the BIMS, indicating she was moderately cognitively impaired. Medical record review of Physician's Orders dated 4/10/13 revealed Resident #15 was ordered Hydrocodone/APAP 5-325 mg every 6 hours as needed for pain. Continued review of orders revealed this was discontinued 6/9/17. Review of the Controlled Drug Record revealed Hydrocodone/APAP signed out on 8/26/17 at 5:00 PM and 11:00 PM and 8/31/17 at 4:00 PM and 10:00 PM by LPN #2.	F 309		

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	445262	A. BUILDING _____ B. WING _____	C 09/13/2017

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F 309	Continued From page 26 Review of the facility investigation revealed the Administrator determined the order was discontinued and the medication was still signed out. Observation of Resident #15 on 9/13/17 at 11:40 AM revealed she was sitting in the dining room eating lunch with no complaints of pain. Medical record review revealed Resident #14 was admitted to the facility on 9/1/17 with diagnoses including Atherosclerotic Cardiovascular Disease and Falls. Medical record review of nursing notes dated 9/1/17 revealed Resident #14 was alert but confused. Medical record review of Physician's Orders dated 9/1/17 revealed Resident #14 was ordered Hydrocodone/APAP 10/325 mg every 6 hours as needled. Review of the Controlled Drug Record revealed on 9/6/16 Resident #14 had received Hydrocodone/APAP at 10:10 AM then it was signed out at 4:00 PM and 9:00 PM by LPN #2. Review of the facility investigation revealed the DON determined the medication was given at too short an interval. Observation of Resident #14 on 9/13/17 at 11:47 AM revealed him sitting on the side of the bed eating lunch. He said he was not in pain but the pain medication helped him. Medical record review revealed Resident #17 was admitted to the facility on 5/30/17 with diagnoses	F 309		

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F 309	Continued From page 27 including Neck Fracture, Chronic Obstructive Pulmonary Disease, Dementia, Congestive Heart Failure, Pulmonary Embolus, Chronic Kidney Disease, Atrial Fibrillation, Pacemaker Insertion, and Gastroesophageal Reflux Disease. Medical record review of the Quarterly MDS dated 8/13/17 revealed Resident #17 scored 15 on the BIMS indicating he was alert, oriented, and able to make his needs known. Medical record review of Physician's Orders dated 5/30/17 revealed Resident #17 was ordered Hydrocodone/APAP 5-325 mg every 6 hours as needed for pain. Review of the Controlled Drug Record revealed Hydrocodone signed out on 9/6/17 at 10:10 AM then at 4:00 PM and 9:00 PM by LPN #2. Review of the facility investigation revealed the DON determined the medication was given at too short an interval. Observation of the resident on 9/13/17 at 2:40 PM revealed Resident #17 resting in bed. He stated he had no pain currently and his pain medications usually control the pain. Medical record review revealed Resident #16 was admitted to the facility on 7/22/15 with diagnoses including Dressler's Syndrome, Arteriosclerotic Cardiovascular Disease, Hypertension, Diabetes Mellitus, Atrial Fibrillation, Cerebrovascular Accident with Left Hemiplegia, aphasia, and Bipolar disorder. Interview with the Administrator on 9/12/17 at 2:20 PM in the Administrator's office confirmed	F 309		

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F 309	Continued From page 28 LPN #2 signed out medications more often than ordered by the Physician. Interview with the DON on 9/13/17 at 10:30 AM in the DON's office confirmed nurses failed to obtain a second signature when wasting narcotics for Resident #12 so did not follow facility policy. Continued interview the DON also confirmed on 9 occasions 1 tablet was signed out to be administered instead of the 1/2 tablet thus failing to follow Physician's Orders. Medical record review revealed Resident #10 was admitted to the facility on 4/9/12 with diagnoses including Bilateral Blindness, Type II Diabetes Mellitus, Vascular Dementia, Peripheral Vascular Disease, Gastro-Esophageal Reflux Disease, Bipolar Disorder, Arthropahty, Hypertension, Hypokalemia, Anemia, Rheumatoid Arthritis (RA), Stage 3 Pressure Ulcer of Left Buttocks & Muscle Wasting & Atrophy. Medical record review of the Quarterly Minimum Data Set (MDS) revealed Resident #10 had a Brief Interview for Mental Status of 4 indicating she was severely cognitively impaired. Further review revealed the resident had no impairment of the lower extremities and was not steady, only able to stabilize with staff assistance with moving from seated to standing position, moving on/off toilet and surface-to-surface transfer. Medical record review of a Clinical Note dated 5/18/17 revealed edema in right ankle. Resident #10 expressed facial grimaces when the nurse touched the ankle and declined to get out of bed. Medical record review of a Physician Assessment dated 5/19/17 revealed "...Pt's [patient's] rt [right]	F 309		

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F 309	Continued From page 29 ankle swollen, erythemoatous, possible deformity noted. Very painful [with] palpitation. Pt doesn't recall any injury to ankle. Was called last night regarding pain to pts hip/ankle, ordered uric acid level for today which is [negative] will get xray ..." Medical record review of a Clinical Note dated 5/19/17 revealed the Nurse Practitioner (NP) ordered an xray of the resident's right ankle. The findings showed comminuted and mildly displaced acute fracture of the tibia and fibula above the joint. NP ordered for the resident to be sent to emergency department (ED). Medical record review of a Radiology Report dated 5/19/17 revealed "...There are comminuted angulated and mildly displaced acute fractures of the distal tibia and distal fibula, well above the joint space. The bones are osteopenic. There appears to be narrowing of the ankle joint. No there acute fractures seen. No other incidental findings...Acute fracture of the distal tibia and fibula..." Medical record review of an ED report dated 5/19/17 revealed Resident #10 had a "...tib-fib [tibia-fibula] fracture..." which was splinted. Resident to follow-up with Physician within 5 to 7 days. Review of a medical record report dated 7/21/17 revealed Resident #10 had a follow-up appointment with an Orthopedic Specialist. Further review revealed "...She was seen on May 19, 2017, when x-rays at nursing facility showed a right distal tibia fracture. She was placed in a splint, but unfortunately never followed up until this week. She is here with her daughter. I questioned her daughter why they never brought	F 309		

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F 309	Continued From page 30 her back even with the followup information that I clearly showed her and that the daughter had with her today and the daughter says she just thought the nursing home would do it...when we touched her right leg, she started screaming...There is a procurvatum deformity at the right distal tibia and equinus flexion contracture of the ankle...Right distal third extraarticular tib-fib fracture sustained 2 months ago, was seen in the ER and told to followup and has not until now...patient is not an operative candidate. Will have to balance the orthopedic treatment for trying to get the bone to heal with risk of skin breakdown and this really is more palliative than anything. She may have a nonunion of the tibia that we treat with bracing long term...we will put her in a short leg cast for some stability at the fracture site. Hopefully this will stimulate some healing...will see her back in a month. We can cut cast off, get another set of x-rays and check on her symptoms. She may be a candidate for a molded removable splint, that may be a good long term option for her..." Review of the medical records from January 2017 until Sept 2017 revealed Resident #10 was never seen by social services. Review of a medical record dated 3/6/17 by social services revealed " ...[Resident #10] received mental health services on this date. A clinical note has been provided and will be scanned into the system for staff review. This social worker will assist [Resident #10] with any social services needs as they arise..." Interview with the Social Worker (SW) #1 on 9/12/17 at 4:30 PM in his office revealed he was responsible for making all follow-up appointments. SW #1 stated he was not aware Resident #10 had a fracture. SW #1 confirmed he	F 309		

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F 309	Continued From page 31 did not make Resident #10 a follow-up as ordered from the ED Physician. SW #1 then stated he had not seen Resident #10 from timeframe May 2017-July 2017. Interview with the Administrator on 9/12/17 at 4:42 PM in her office confirmed the facility failed to ensure Resident #10 received a follow-up orthopedic appointment as ordered. Interview with the Administrator on 9/13/17 at 12:45 PM revealed she expected Social Services to have contact with residents at least quarterly if not more. The Administrator confirmed Resident #10 had not been assessed by Social Services since January 2017	F 309		
F 514 SS=D	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident;	F 514		

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F 514	Continued From page 32 (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to ensure complete and accurate medical records for 5 residents (#1, #2, #3, #4, #5) of 17 residents reviewed. The findings included: Medical record review revealed Resident #1 was admitted to the facility on 8/1/17 with diagnoses including Atherosclerotic Cardiovascular Disease, Post Traumatic Stress Disorder, Gastroesophageal Reflux Disease, Deep Vein Thrombosis, Diabetes Mellitus, Hypertension, and Chronic Pain. Medical record review of the Admission Minimum Data Set (MDS) dated 8/6/17 revealed Resident #1 scored 15 on the Brief Interview for Mental Status (BIMS) indicating he was alert, oriented, and able to make his needs known. Medical record review of Physician's Orders dated 8/6/17 revealed Resident #1 was ordered	F 514		

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F 514	Continued From page 33 Oxycodone 7.5/325 milligrams (mg) every 6 hours as needed for pain. Review of the Controlled Drug Record revealed on 8/15/17, Oxycodone 7.5/325 mg was signed out at 9:00 PM, 10:00 PM, 2:00 AM. Continued review revealed Oxycodone was also signed out on 8/16/17 at 6:00 AM. Medical record review of the Medication Administration Record (MAR) revealed Oxycodone 7.5/325 mg was documented as administered at 3:40 PM on 8/15/17 and at 1:33 PM on 8/16/17. None of the other times from the evening and night shifts were documented on the MAR. Review of the facility investigation revealed Resident #1 was interviewed on 8/16/17 and stated he received pain medication about 8:30 PM on 8/15/17 but did not receive any pain medication during the night on the 11:00 PM - 7:00 AM shift and he slept through the night. Medical record review revealed Resident #2 was admitted to the facility on 12/24/13 with diagnoses including Diabetes Mellitus, Hypertension, Dementia, Obstructive Sleep Apnea, Bipolar Disorder, Seizures, and Colostomy. Medical record review of the Quarterly MDS dated 9/1/17 revealed Resident #2 scored 15 on the BIMS indicating she was alert, oriented, and able to make her needs known. Medical record review of Physician's Orders dated 2/17/17 revealed Resident #2 was ordered Oxycodone 7.5/325 mg every 4 hours as needed for pain.	F 514		

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F 514	Continued From page 34 Review of the Controlled Drug Record revealed Oxycodone 7.5/325 mg was signed out at 12:00 AM, 2:00 AM, 6:00 AM, 6:45 AM, and 6:55 AM, all by Agency Nurse #1. Continued review of the Controlled Drug Record revealed only 1 tablet was signed out at 12:00 AM but the count was documented as 29 before the tablet was removed and 27 after the tablet was removed. Further review revealed only 1 tablet was signed out at 2:00 AM but the count was documented as 27 before the tablet was removed and 25 after the tablet was removed. Continued review revealed 1 tablet was signed out at 6:00 AM but the count was documented as 25 before the tablet was removed and 23 after the tablet was removed. Further review revealed at 6:45 AM and 6:55 AM Agency Nurse #1 documented removing 2 tablets each time. Medical review of the MAR revealed Oxycodone 7.5/325 mg was documented as administered on 8/15 17 at 10:53 PM but nothing was documented for 8/16/17. Review of the facility investigation revealed Resident #2 was interviewed on 8/16/17 and she stated she received pain medication on the 3:00 PM - 11:00 PM shift but did not have any pain medication during the night and was not having any increase in her pain. Medical record review revealed Resident #3 was admitted to the facility on 7/8/16 with diagnoses including Hypertension, Chronic Kidney Disease, Diabetes Mellitus, Dementia, and Decreased Mobility. Medical record review of the Annual MDS dated	F 514		

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F 514	Continued From page 35 6/30/17 revealed Resident #3 scored 13 on the BIMS indicating she had slight cognitive impairment. Medical review of Physician's Orders dated 7/21/17 revealed Resident #3 was ordered Oxycodone 5/325 mg every 12 hours as a scheduled medication. Review of the Controlled Drug Record dated 8/5/17 revealed Oxycodone 5/325/mg was signed out at 6:00 PM and 11:00 PM while on 8/6/17 it was signed out at 6:00 AM, 5:00 PM, and 11:00 PM. Continued review revealed on 8/7/17 Oxycodone was signed out at 5:30 AM, 9:00 PM, and 11:00 PM while on 8/9/17 it was signed out at 9:30 PM, 10:30 PM, and one was wasted at 11:30 PM. Further review revealed on 8/10/17 Oxycodone was signed out at 6:00 AM and on 8/13/17 was signed out at 12:00 AM and 6:00 AM. Continued review revealed on 8/14/17 Oxycodone was signed out at 12:00 AM, again for 12:00 AM, 6:00 AM, 6:30 AM, and 6:50 AM. Further review revealed on 8/15/17 Oxycodone was signed out at 4:00 PM and 10:00 PM while on 8/16/16 it was signed out at 12:00 AM, 6:00 AM, and 6:45 AM. All of these removals were signed out by Agency Nurse #1. Medical record review of the MAR revealed the only documentation of administration of Oxycodone was 8/7/17 at 5:30 AM. There was no documentation for the rest of the tablets of Oxycodone which were removed. Medical record review revealed Resident #4 was admitted to the facility on 7/20/17 with diagnoses including Hypertension, Gastroesophageal Reflux Disease, Acute Kidney Failure, and Paraplegia.	F 514		

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F 514	Continued From page 36 Medical record review of the Admission MDS dated 7/27/17 revealed Resident #4 scored 15 on the BIMS, indicating he was alert, oriented, and able to make his needs known. Medical record review of Physician's Orders dated 7/20/17 revealed an order for Oxycodone 5 mg IR 1 tablet every 6 hours as needed for pain. Review of the Controlled Drug Record revealed on 8/5/17 Oxycodone was signed out at 6:15 PM and 11:45 P0 AM; on 8/12/17 it was signed out at 2:00 AM; on 8/13/17 it was signed out at 3:15 AM; on 8/14/17 it was signed out at 12:00 AM and 6:00 AM; on 8/15/17 it was signed out at 7:00 PM' and on 8/16/17 it was signed out at 1:00 AM. All these removals were signed out by Agency Nurse #1. Medical record review of the MAR revealed no documentation on the MAR of any of these medications being administered. Medical record review revealed Resident #5 was admitted to the facility on 4/28/17 with diagnoses including Acute Respiratory Failure, Tension Pneumothorax, Cerebrovascular Accident with Right Hemiplegia, Hypertension, and Chronic Pain. Medical record review of the Quarterly MDS dated 8/1/17 revealed Resident #5 scored 3 on the BIMS indicating she was severely impaired cognitively. Medical record review of Physician's Orders dated 4/28/17 revealed Resident #5 was ordered Oxycodone 5/325 mg three times daily.	F 514		

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F 514	Continued From page 37 Review of Controlled Drug Record dated 8/3/17 revealed Oxycodone was signed out at 5:00 PM, 10:00 PM, 11:00 PM, again at 11:00 PM, and 11:30 PM. Continued review revealed on 8/4/17 Oxycodone was signed out at 5:00 PM, 5:30 PM, 10:30 PM, and 11:00 PM. Further review revealed on 8/6/17 Oxycodone was signed out at 5:00 AM, 5:00 PM, and 11:00 PM. Continued review revealed on 8/12/17 Oxycodone was signed out at 12:00 AM, 4:00 AM, and 6:00 AM while on 8/13/17 it was signed out at 12:00 AM and 6:00 AM. Further review revealed on 8/14/17 Oxycodone was signed out at 12:00 AM and 6:00 AM while on 8/15/17 it was signed out at 10:00 PM, 10:30 PM, 12:00 AM, and 6:00 AM. These removals were all signed out by Agency Nurse #1. Medical record review of the MAR revealed none of these removals were documented as having been administered. Interview on 9/13/17 at 2:20 PM in the Administrator's office, the Administrator confirmed medications were not documented on the MAR when signed out on the Controlled Drug Record. The Administrator confirmed this resulted in an incomplete medical record.	F 514		